TopMed Medical Scheme
PO Box 1462, Durban, 4000
Client Services: 0860 00 21 58
Website: www.topmed.co.za

AMENDMENT FORM

To be completed for the following amendments

- Change of address
- Change of contact details
- Change of banking details
- Addition of dependant
- Removal of dependant

A DETAILS OF THE MEMBER

Surname

Full Name(s)

Membership Number

B CHANGE OF ADDRESS

Postal Address

Postal Code

Physical Address

Postal Code

C CHANGE OF CONTACT DETAILS

Email Address

Telephone (home)

Telephone (work)

Cellphone Number

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D DEBIT/CREDIT ORDER INSTRUCTION

Member Name

Member/Group Number ID Number

Telephone Number

Postal Address

Postal Code

TO WHOM IT MAY CONCERN

Debit Credit

The details of my/our bank account is/are as follows:

Name of Account Holder

Name of Bank

Branch Name Branch Code

Account Number

Account Type Current Savings Transmission

PLEASE NOTE THAT CREDIT CARD TRANSACTIONS ARE NOT ALLOWED AGAINST YOUR MEDICAL AID CONTRIBUTIONS AND REFUNDS.

I/We hereby instruct and authorise you to debit/credit amounts which may be due to/by me/us to the debit/credit of my/our account with the abovementioned bank, or any other bank to which I/we may transfer my/our account.

I/We understand that the debit/credit transfers hereby authorised will be processed by computer through a system known as ACB Magnetic Tape Service and I/we also understand that no advice of the debit/credit will be provided by my/our bank, but details of each debit/credit will be printed on my/our statement or on any accompanying voucher.

I/We agree to pay any bank charges relating to the debit order instruction.

I/We understand that Billing advices and details will be supplied in the normal way and that the debit/credit will be actioned at least ten days after the date of Statement to/from my/our account.

This authority may be cancelled by me/us by giving thirty days written notice, sent by prepaid registered post, but I/we understand that I/we shall not be entitled to any refund amounts which have been withdrawn while this authority was in force if such amounts were legally owing by me/us.

SIGNATURE OF ACCOUNT HOLDER (MANDATORY) _____ DATE D D M M Y Y Y Y

SIGNATURE OF PRINCIPAL MEMBER (MANDATORY) _____ DATE D D M M Y Y Y Y

SIGNATURE OF GROUP / EMPLOYER (WHERE APPLICABLE) _____ DATE D D M M Y Y Y Y

SIGNATURE OF BROKER / INTERMEDIARY (WHERE APPLICABLE) _____ DATE D D M M Y Y Y Y

PLEASE NOTE: Changes to your banking details will only be processed upon receipt of a valid copy of your identity document attached to this application.

You will receive your Billing statement and details as usual and the debit order will be actioned at least ten days after the date of statement. If for some reason you do not agree with the statement and do not want the Debit Order actioned, kindly telephone us on **0860 00 21 58** so that alternate arrangements can be made.

GROUP STAMP

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E ADDITION OF DEPENDANT

Start Date D D M M Y Y Y Y

Please complete section J (UNDERWRITING QUESTIONS) in full for all additional dependants.
In the case of newborns added within 30 days of birth, please attach a copy of ID Document or Birth Certificate.

Full Name(s)	**Surname**	**Gender M / F**	**ID Number (compulsory)**	**Relationship** (spouse, son, partner*, etc)

- **All newborns must be registered within 30 days of birth as a dependent of the Principal Member.**
- **Proof of Student Registration must be attached for all dependent children aged 21-24 years.**
- **Copies of ID documents/birth certificates must be attached for all dependants.**

I hereby declare that the insured persons with different surnames, are related to me as:

Biological child ☐ Adopted child * ☐

Step child ☐ Married to Principal Member ☐

Foster child * ☐ Partner ** ☐

Please note:
***** Foster/Adopted child - proof of legal guardianship is required.

** Partner - a person with whom the Member has a committed and serious relationship simliar to that of a marriage in which there is mutual, financial and emotional support and a shared household, irrespective of the gender of either party.

DETAILS OF PREVIOUS MEDICAL SCHEME MEMBERSHIP REQUIRED IF DEPENDANT (OLDER THAN 21) BELONGED TO ANOTHER MEDICAL SCHEME

A membership certificate for your dependants' present/previous medical scheme(s) is required. If a membership certificate cannot be supplied, please provide an affidavit with all the information regarding your dependants' (older than 21 years) present/previous medical scheme(s) cover.

Yes ☐ No ☐

Name of Scheme
Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

Name of Scheme
Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

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Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

Name of Scheme
Membership No.
Date of Joining D D M M Y Y Y Y
Resignation Date D D M M Y Y Y Y

Is your dependant compelled to terminate membership at their current/previous medical scheme because of change of employment? Yes ☐ No ☐

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F REMOVAL OF DEPENDANT

Surname | Initials

Full Name(s) (including any names or nicknames)

ID No. of Dependant | Date of Resignation D D M M Y Y Y Y

Reason

Surname | Initials

Full Name(s) (including any names or nicknames)

ID No. of Dependant | Date of Resignation D D M M Y Y Y Y

Reason

G DECLARATION BY MEMBER

I hereby declare that the information in this document, whether it is in my own handwriting or not, is complete and correct.

Signature (Principal Member)

Date D D - M M - 2 0 Y Y

H TO BE COMPLETED BY EMPLOYER IF MEMBER HAS COMPLETED SECTIONS E AND F

Name of Employer

Group Number

Total current contribution R

Total new contribution R

Arrears (if applicable) R

Signature (Employer)

Company Stamp

Date D D - M M - 2 0 Y Y

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I UNDERWRITING QUESTIONS

In order to add a Dependant to your membership, please complete the questionnaire below:

PLEASE ANSWER YES ☑ OR NO ☒ TO EVERY QUESTION FOR EVERY BENEFICIARY.

		APPLICANT	SPOUSE	DEPENDANT 1	DEPENDANT 2	DEPENDANT 3	DEPENDANT 4
1	High Blood Pressure, High Cholesterol or lipids, Ischaemic Heart Disease, heart failure, Angina, Stroke (CVA) or Peripheral Vascular Disease						
2	Obstructive Lung Disease (Asthma, Emphysema or C.O.A.D)						
3	Diabetes (Insulin or Non-insulin Dependant Diabetes Mellitus)						
4	Hypo or Hyperthyroidism						
5	Arthritis (i.e. Osteo, Rheumatoid Arthritis or Gout) - all related musculoskeletal conditions						
6	Osteoporosis						
7	Gastro Oesophageal Reflux Disease (G.O.R.D/heartburn) or stomach/duodenal ulcers (please circle)						
8	Immune Deficiency status (i.e. HIV/AIDS*, immunoglobulin deficiencies)						
9	Anaemia or abnormalities of clotting mechanism						
10	Hormone Replacement Therapy, Endometriosis or ovarian cysts						
11	Depression and/or anxiety disorders						
12	Any nervous or mental complaint (e.g. Epilepsy, blackouts, paralysis or headaches)						
13	Glaucoma, cataracts or any other disorders of the eye						
14	Parkinson's Disease or Multiple Sclerosis (please circle)						
15	Hyperplasia of prostate (BPH) or Prostatism						
16	Inflammatory Bowel Disease (Crohns Disease or Ulcerative Colitis)						
17	Urinary tract infection or calculi (stones)						
18	Back or neck related condition (lumbago, sciatica, injury, spasm, etc)						
19	Are you pregnant? If so, how many weeks?						
20	Have you had any surgical procedure during the past 12 months or are you planning a surgical procedure for the following 12 months?						
21	Are you on any medication at present?						
22	Is there any other condition or symptom, which is not detailed in any other question, for which medical advice, diagnosis, care or treatment has already been recommended or received by you or which you anticipate receiving, and could potentially result in a medical claim within the next 12 months?						
23	Skin conditions/disorders (e.g Acne, Eczema, Psoriasis, etc)						
24	Ear, nose or throat disorders (e.g. ear discharge, recurrent Tonsillitis)						
25	Infectious diseases (e.g. Tuberculosis, Shingles, Measles, etc)						
26	Malignant neoplasms (cancer, growths or malignant tumours)						
27	Benign neoplasms (non-malignant tumours/growths)						
28	Specialised dentistry/maxillo-facial treatment						
29	Have you had or are you expecting to have plastic or reconstructive surgery?						
30	Do you or your dependants take chronic medication?						

* Should you be HIV positive and do not wish to disclose this on your application form, please note that once you have received your membership (Contract) number, we require you to please fax confirmation of your HIV/AIDS status to our HIV/AIDS Department on **0860 448 2273**. Please note that this may result in you receiving a second card from the Scheme depending on whether your application will require underwriting as per current legislation.

IF YOU HAVE ANSWERED 'YES' TO ANY OF THE ABOVE QUESTIONS, PLEASE PROVIDE DETAILS BELOW. FAILURE TO DISCLOSE ANY PRE-EXISTING CONDITIONS COULD RESULT IN BENEFITS BEING LIMITED, EXCLUDED AND/OR MEMBERSHIP BEING TERMINATED.

Question No.	Nature and duration of complaint and full details of treatment being received or expected to be received	Name and telephone number of attending doctor or hospital	When did you last have symptoms or last receive treatment?

NB: Failure to disclose any pre-exisinting conditions could result in benefits being limited, excluded and/or membership being terminated.

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